# Dissemination of Information and Early Intervention Practices in the Context of Mass Violence or Large-Scale Disaster

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The events of September 11, 2001, raise important questions for the design of rapid mental health response to catastrophes that affect large numbers of people. As a result of the assaults on the World Trade Center and the Pentagon, many mental health providers will encounter trauma survivors in routine care, or be tasked to provide services related to the terrorist attack. These providers require training to adapt their existing counseling skills to mass violence and disaster mental health contexts, and to learn about evidence-based trauma care. Such a need for training forces consideration of two key issues: What should these providers be trained to do, and how should this information be disseminated to such a large number of providers?

## What to Disseminate?

The question of what to teach providers delivering mental health care to survivors of mass violence and disaster is not clearly answered by a look at the existing empirical literature. Most of what is currently advocated and delivered as "disaster mental health care" has not been subjected to careful empirical evaluation.

Cognitive-behavioral methods are probably the most thoroughly studied interventions targeting chronic PTSD, and they figure importantly in emerging treatment guidelines for PTSD (Foa, Keane, & Friedman, 2000). Briefer versions of these treatments are seeing increasing application in the context of early intervention posttrauma (e.g., Bryant, Sackville, Dang, Moulds, & Guthrie, 1999; Foa, Hearst-Ikeda, & Perry, 1995), and initial findings suggest that brief, early intervention may play a role in prevention of PTSD. However, the evidence base for these methods is as yet small. More importantly, these interventions have been applied with accidents and assaults on individuals and not in the contexts of large-scale disaster, mass violence, or terrorism. Also, as currently designed, these "brief" approaches require approximately 8 hours of care by trained practitioners.

If the evidence base for brief cognitive-behavioral approaches is lacking, the evi-

dence for other preventive interventions is weaker still. In the absence of the kind of database needed, the goal of providing evidence-based early intervention services must, for a time, be approximated, through the delivery of evidence- and theory-consistent services. This means that selection of training content must rely not on unassailable evidence for its justification, but on clinical judgment and familiarity with theory and research findings in the field of traumatic stress and grief. Following such thinking, various federal agencies and other professional bodies are beginning to seek consensus on current best practices (e.g., www.ncptsd.org/facts/disasters/fs_consensus.html).

Certainly, much of what is delivered postdisaster is consistent with knowledge about factors that can affect human response to trauma. The provision of practical helping services (e.g., financial compensation, living accommodations) may help prevent the resource loss that has been related to posttrauma distress (e.g., Freedy, Shaw, Jarrell, & Masters, 1992). Reconnection with loved ones and the delivery of alternative forms of interpersonal help (e.g., support groups) are consistent with findings indicating the role of social support in recovery (e.g., Kaniasty & Norris, 1993). Much of the thinking underlying current practice in disaster mental health assumes that intense initial reactions are normal and that helping survivors to accept their reactions without labeling themselves (e.g., as "weak" or "crazy") will be helpful. Emphasis is therefore placed on avoiding mental health terminologies and diagnostic constructs, and survivors are taught about common, expected reactions to trauma. Such an approach is broadly consistent with findings of considerable acute stress symptomatology in most survivors exposed to severe trauma (Bryant & Harvey, 2000), and consistent with theoretical models that attend to posttrauma cognition. The emphasis in disaster mental health on outreach services intended to contact survivors where they live or gather is consistent with evidence that many individuals with PTSD do not seek mental health treatment. Finally, much of mental health response is concerned with advice regarding potentially helpful coping skills. Survivors are encouraged to seek support, maintain normal routines, eat healthily, seek counseling as needed, and so on. Workers are told to take breaks and time off, spend time with family and friends, exercise, and talk to others. All are admonished to avoid social withdrawal, workaholism, and alcohol and drug use as ways of "coping." Brief education and advice can sometimes change behavior, and some of these do's and don'ts of coping are consistent with research and theory.

At present, we do not know whether these services produce desired changes in survivor behavior or whether such behaviors are associated with better outcomes. And we don't know, therefore, what kind of training to offer to mental health workers. Most of what is delivered in the initial weeks post-event can be labeled practical and emotional support and brief education rather than psychotherapy. According to this way of thinking, disaster mental health workers need not be specialists in posttraumatic stress; they are there to provide limited, practical support services and to identify and refer those in need of additional help. Therefore, the general counseling skills presumably possessed by mental health professionals (or even the personal qualities possessed by well-selected paraprofessionals), combined with specific training regarding the context of disaster, should be adequate to the helping task, and training should be designed to bring professionals up to speed in a new service delivery context. It should focus on the differences between traditional mental health care and care as delivered in situations of mass violence, content of basic survivor education, informal assessment skills, and procedures for referral to more intensive services. This model fits with the real-world demands of the postdisaster environment, in which it cannot be assumed that large numbers of specialists, or even mental health professionals, will be available in affected communities. It also fits with a key idea in disaster mental health thinking, that the best way to help communities is to enable them to help themselves. However, those accustomed to working with trauma survivors in more traditional mental health settings will question whether brief training for nonspecialized workers will really enable them to deliver sensitive and accurate education about stress and grief reactions, adequately assess survivors, or decide who requires referral. These questions should be answered not through argument based on a clash of models, but through empirical investigation. Does education delivered by experts have more impact than education provided by paraprofessionals? How do the groups differ in terms of their ability to detect those in need of formal help? In the meantime, systems of supervision, perhaps implemented in part using new technologies (see below), should be used to link inexperienced workers to those knowledgeable about treatment of trauma-related problems.

The lack of an evaluation literature examining early intervention in the contexts of mass violence and large-scale disaster raises important issues for the field. Much is currently known about risk factors for development of chronic PTSD and other posttrauma problems; however, ways to prevent those problems have not been established. Therefore, questions can be raised about the appropriateness of screening trauma survivors and referring at-risk individuals to specialized early intervention services that are not known to be effective. One question concerns the possible harm caused by identifying an individual as needing more intensive care. Possibly, such identification might magnify the impact of the event. For example, the person might be viewed by others as less able to cope, or might come to see his or her reactions as abnormal, and focus more attention on symptoms. Emergency workers identified as needing services might be subject to discrimination regarding future job assignments. Against such hypothetical risks must be weighed the consequences of failing to refer individuals likely to have continuing difficulties. Research investigating the possible iatrogenic effects of identification and service delivery to those identified as "at risk" is currently lacking and is likely to be important. The recent controversy over the use of stress debriefing methods illustrates the increasing emphasis in the context of disaster response that mental health providers first "do no harm." The small body of randomized controlled trials examining individual debriefing has not produced evidence that debriefing prevents PTSD, and two studies have even suggested that it may in fact worsen some symptoms. Although it can be argued that these studies have not tested those forms of group debriefing most frequently employed in the field, these results have led many experts to caution against routine use of debriefing procedures at present.

As postdisaster services continue to be offered in the months and years following the event, the evidence base available to inform design of training becomes stronger. Mental health providers begin to see those with chronic PTSD and other problems. This means that the content of training will change over the period following mass violence, with services evolving to become more similar to those employed in more traditional psychotherapeutic settings. With regard to PTSD, however, the best-validated treatment methods are unlikely to be in the repertoires of most mental health providers, so that the burden on training and supervision will increase, not disappear. Relatively brief training of nonspecialist treatment providers may be appropriate if it focuses on screening, identification, and referral to appropriate helping resources. Those who receive these referrals and are tasked to provide treatment will require

more extensive training and supervision. In line with such thinking, an innovative service delivery approach is being implemented in New York City, where a group of mental health professionals have received training in evidence-based PTSD and grief treatments, designed to provide more intensive services for survivors.

### Just-in-Time Training for Providers: The Role of New Technologies?

As much as possible, mental health training should be accomplished before disaster strikes, as part of ongoing professional education and community disaster planning. However, much training will by necessity be delivered post-event. This training will need to reach a variety of audiences, including mental health professionals who must now apply their skills to an unfamiliar situation, paraprofessionals with little or no experience of such work, and primary care providers who will need to address traumatic, stress-related physical health complaints in their patients. It is certain that, in a large terrorist event such as that affecting New York, many thousands of health care professionals will encounter those affected, shortly following the event and at later times, in their existing service contexts or as part of services specifically designed to meet disaster-related needs.

Although face-to-face trainings are important, they are likely to be insufficient to meet the training needs of helpers, and will need to be supported by written materials and other forms of dissemination. In principle, the Internet has a number of features that may be increasingly helpful in this regard in the future. First, at relatively low development cost, the Internet has the potential to reach large numbers of persons. Second, the Web can also enable content to be modified or "customized," as appropriate, according to the specifics of a given traumatic event or audience. Third, if organized through credible, authoritative organizations, it can enable quality control of information, training content, and trainer expertise. In an increasingly glutted information environment, the Web can help providers and administrators find needed information and give helpers access to the best quality of training. Probably the simplest way of achieving quality control is for the primary organizations charged with disaster mental health response (e.g., the Center for Mental Health Services) to determine and assist in delivery of appropriate information and training content.

The growing role of the Internet as a posttrauma resource was seen following the terrorist attacks on the Pentagon and World Trade Center. Web sites all over the world were mobilized to communicate caring and concern for survivors and workers, and to provide information and advice to victims and helpers. For example, a large variety of materials were mounted on the National Center for PTSD Web site (www.ncptsd.org) to help survivors, providers, and the general public, covering such topics as terrorism and children, management of grief, pharmacological treatment of acute stress reactions, casualty and death notification, the effects of media coverage on the community, and how terrorist attacks may affect veterans. From January to September 2001, the mean number of requests from separate individuals per day was 5,700. However, following the terrorist attacks of September 11, the number of requests per day ranged from 12,164 to 31,364.

As of yet, however, the potential of the Web remains to be fully utilized in the aftermath of disaster. The Web can be harnessed to keep mental health responders informed about the rapidly evolving posttrauma environment. Electronic mailings could be made available to responders to mass violence, providing them with informational updates (e.g., about the changing circumstances regarding body recovery, or about changes in service availability), newly developed survivor educational materials, and so on. In the future, Internet-delivered audio- and video-streaming will enable training materials, including practice demonstrations, to be made available to large numbers of providers. Mental health workers will use the Web to feed in their experiences, completing assessment tools online that will help inform the ongoing design of mental health response across the months following the event. Helpers will be able to share experiences with one another on-line, and consult supervisors.

It is likely that groups of survivors, too, can be reached via the Internet. This means that agencies coordinating disaster response will be afforded a new means of communicating directly to survivors. Survivors can be expected to increasingly supplement their face-to-face support for one another with virtual support facilitated by discussion forums, and to access expert support in the same manner. The Web can provide survivors with a tool to collectively articulate their concerns and needs and give service developers a new way of listening more closely to their clients. It may also present additional risks for harm to survivors that may need to be addressed through monitoring of Web-based interactions.

### Final Thoughts

The field of early intervention with traumatized populations is developing rapidly and is entering a new period in which evidence will increasingly be expected to inform the design of services and the training of providers in the delivery of those services. Researchers will be increasingly called upon to determine the effectiveness of service options, and practices will be modified to reflect the evidence base and current thinking about traumatic stress. The events of September 11 will accelerate these advances. Despite challenges related to issues of confidentiality, novelty, and controllability, it is also likely that newer information technologies will be brought to bear on mass violence and disaster care because of the

need for mass dissemination and cost and logistical limitations associated with face-to-face training. Because CBT treatment researchers are well placed to examine the effectiveness of current practices in disaster mental health and to adapt what has been learned about brief intervention methods in other domains of care to enhance the impact of brief postcatastrophe services, and because many cognitive-behavioral treatments are compatible with an "educational" model of service delivery, CBT methods can be expected to figure prominently in developments in mass violence and disaster response.

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